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# IN THE
# Supreme Court of the United States

ALBERTO R. GONZALEZ, ATTORNEY GENERAL
OF THE UNITED STATES, *ET AL.*

PETITIONERS,

*v.*

STATE OF OREGON, *ET AL.*,

RESPONDENTS.

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

## BRIEF OF FOCUS ON THE FAMILY AND THE FAMILY RESEARCH COUNCIL AS *AMICI CURIAE*, SUPPORTING PETITIONERS

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## INTEREST OF AMICI CURIAE

This *amicus curiae* brief is filed on behalf of Focus on the Family and the Family Research Council.[1]

**Focus on the Family** is a non-profit religious corporation committed to strengthening the emotional, psychological, and spiritual health of children and their families in the United States and throughout the world.

Focus on the Family's Founder and Chairman, Dr. James Dobson, a distinguished child psychologist, is the author of numerous books, pamphlets, and papers on child development, education, marriage, and society. Focus on the Family and Dr. Dobson have been at the forefront of the pro-life movement and have spoken and written extensively concerning individual and societal dangers associated with assisted suicide. Focus on the Family has participated as *amicus curiae* on numerous briefs to this Court and others in cases addressing issues of life. It regularly lobbies Congress and state legislatures concerning matters associated with the sanctity and preservation of life. *See* www.family.org.

**Family Research Council** is a non-profit, research and educational organization dedicated to articulating and advancing a family-centered philosophy of public life. FRC is a voice for the pro-family movement in Washington, D.C., and provides policy analysis, legislative assistance, and research for pro-life and pro-family organizations. It also

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[1] In accordance with Supreme Court Rule 37(6), *amici* certify that this brief was authored entirely by Counsel of Record for *amici* and that no part of the brief was authored by any attorney for a party. The Alliance Defense Fund provided a monetary contribution to the preparation or submission of this brief; no other person or entity other than *amici curiae* or their counsel provided a monetary contribution to the preparation or submission of this brief.

seeks to educate legislators on issues that affect American families.

In addition to providing policy research and analysis for the legislative, executive, and judicial branches of the federal government, FRC works to inform the news media, the academic community, business leaders, and the general public about family issues that affect the nation. FRC publishes and disseminates resource materials, legal memoranda, and public policy studies on pro-family issues. These publications include discussions on the problems and legal controversies surrounding assisted suicide. *See* www.frc.org. Its research, publications, and films on the impact of assisted suicide have been distributed to thousands of scholars, students, organizations, and citizens. FRC's legal and public policy experts are continually sought out by members of Congress and state legislators for assistance and advice on matters of bioethics and issues relating to assisted suicide.

FRC has participated in numerous *amicus curiae* briefs in the United States Supreme Court and federal courts, including cases involving pro-life issues.

Focus on the Family and Family Research Council work to preserve and protect the family and have particular knowledge about the social and legal impact of assisted suicide that will be helpful to the Court in this case.

## CONSENT TO FILE BRIEF

Petitioner and Respondents, through their counsel of record, consented to the filing of this Brief of *Amici Curiae* in support of Petitioner. Their letters of consent are on file with the Clerk of the Court.



## SUMMARY OF THE ARGUMENT

The issues in this case implicate important federalism concerns vital to proper constitutional governance under the rule of law.

The appellate court's analysis, granting Oregon's request to enjoin the United States from enforcing the Federal Controlled Substances Act (CSA), is incompatible with the Supremacy Clause in Article VI of the United States Constitution. Mutually exclusive provisions of the Federal CSA and Oregon law make it impossible for a dispensing physician to comply with both. In such situations, this Court has deemed the state law preempted—even where a distinctive state interest is at stake. *See, e.g.*, *Hisquierdo v. Hisquierdo*, 439 U.S. 572, 581 (1979) (finding state community property law preempted by federal military pay law). Thus, even *without considering* the Attorney General's reasonable interpretation of the CSA's implementing regulation, the two statutes here conflict to the extent they cannot consistently stand together.

The CSA, as interpreted by the Attorney General, does not interfere with Oregon's regulation of a traditional state function. The Oregon law authorizes and protects a non-traditional, deadly practice, using federally controlled substances—a practice condemned by the American Medical Association and our nation's leading health care provider associations. This deadly practice cannot be a traditional state function as Oregon professes it to be. As such, Oregon has no right to prevent federal enforcement of the applicable federal drug laws under the CSA.

The Attorney General's interpretive rule confirmed that dispensing controlled substances to assist suicide violates the CSA, and merely verified that assisting suicide is

not a "legitimate medical purpose" within the meaning of 21 C.F.R. 1306.04. Pet. App. 100a (AG Order no. 2534-2001). When this interpretation of the CSA's implementing regulation is added into the analysis, federal preemption is irrefutable. In promulgating this interpretive rule concerning the dispensing of controlled substances, the Attorney General acted within the scope of his statutory authority.

Finally, enjoining the United States from protecting the citizenry against dispensing drugs to kill a human being creates a culture of death with serious implications.

*Amici*, therefore, urge this Court to reverse the decision of the United States Court of Appeals for the Ninth Circuit.

## ARGUMENT

### THE COURT OF APPEALS ERRED IN GRANTING OREGON'S REQUEST TO ENJOIN THE UNITED STATES FROM ENFORCING THE FEDERAL CONTROLLED SUBSTANCES ACT (CSA)[2]

The issues in this case implicate important federalism concerns vital to proper constitutional governance under the rule of law.

#### A. CONGRESS, PURSUANT TO ITS ENUMERATED POWERS IN ARTICLE I OF THE UNITED STATES CONSTITUTION, MAY REGULATE THE DISPENSING OF CONTROLLED SUBSTANCES BY PHYSICIANS AND OTHER MEDICAL PROFESSIONALS

Article I, of the United States Constitution, vests in Congress the power "[t]o regulate Commerce ... among the several States," U.S. Const. art. I, § 8, cl. 3. Additionally, the

[2] 21 U.S.C. §§ 801 *et seq.*



Necessary and Proper Clause, empowers Congress to enact laws reasonably necessary to carry out its power under the Commerce Clause. *Id.* at cl. 18.

This Court has held that "Congress's commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce, . . . i.e., those activities that substantially affect interstate commerce." *See United States v. Morrison*, 529 U.S. 598, 609 (2000) (quoting *United States v. Lopez*, 514 U.S. 549, 558-59 (1995)). *See also United States v. Darby*, 312 U.S. 100, 118 (1941). Congress properly exercised such Article I powers when enacting the Federal Controlled Substances Act.

Under a "rational basis" standard, broad deference is due to congressional judgments concerning whether drug dispensing activity by physicians substantially affects interstate commerce. *See Lopez, 514* U.S. at 557. Likewise, such broad deference applies to whether Congress's regulation of drugs is reasonably necessary to carry out its legislative purpose under the Commerce Clause. *Id.*[3] Here, it is clear that Congress's purpose in enacting the Controlled Substances Act was to comprehensively regulate the market of such substances. A House Report expressly stated that Congress promulgated the law in order "to deal in a comprehensive fashion with the growing menace of drug abuse in the United States . . . through providing more effective means for law enforcement aspects of drug abuse prevention and control." H.R. Rep. No. 91-1444, Pt. 1, at 1 (1970), *reprinted in* 1970 U.S.C.C.A.N. 4566, 4567.

[3] "A court may invalidate legislation enacted under the Commerce Clause only if it is clear that there is no rational basis for a congressional finding that the regulated activity affects interstate commerce, or that there is no reasonable connection between the regulatory means selected and the asserted ends." *Hodel v. Indiana*, 452 U.S. 314, 323-24 (1981).

When it enacted the Federal Controlled Substances Act, Congress made the following findings and statements:

> (1) Many of the drugs included within this subchapter have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.
>
> (2) The illegal . . . distribution, and possession *and improper use* of controlled substances have a substantial and detrimental effect on the health and general welfare of the American people. (emphasis added)
>
> (3) A major portion of the traffic in controlled substances flows through interstate and foreign commerce. Incidents of the traffic which are not an integral part of the interstate or foreign flow, such as manufacture, local distribution, and possession, nonetheless have a substantial and direct effect upon interstate commerce . . . . 21 U.S.C. § 801.

From these and its other findings, Congress could reasonably assume that the dispensing of drugs substantially affects interstate drug commerce. It is also reasonable that federal regulation of such an activity is necessary to accomplish the congressional purpose of regulating drug commerce. Congress properly, therefore, could conclude that regulation of drug-dispensing activity is a reasonably necessary way to achieve its purpose of comprehensively regulating the interstate market in controlled substances. Including improper drug-dispensing activity for lethal purposes within the CSA's coverage furthers its legitimate objective. Indeed, excepting such activity undermines clear legislative intent to



regulate the drug market comprehensively in a manner which protects public health and safety.[4]

Moreover, no constitutional provision limits Congress from using its powers under Article I to regulate commerce in connection with medical matters. *See Darby*, 312 U.S. at 115-17 (1941) (renouncing earlier doctrines holding that Congress could not utilize the commerce power to achieve legitimate objectives relating to the health and welfare of the nation); and *see generally*, *United States v. Steele*, 147 F.3d 1316, (11th Cir. 1998) (en banc) (and cases cited therein), *cert. denied*, *Steele v. United States*, 528 U.S. 933 (1999)(upholding a conviction of a physician under the CSA for dispensing drugs outside professional limits).

### B. The Federal Controlled Substances Act Preempts the Oregon Law Authorizing Doctors to Dispense Drugs to Assist Killing a Human Being

The relevant Oregon law in this case authorizes physicians, in certain circumstances, to prescribe and dispense a lethal amount of drugs for the purpose of assisting in the killing of a human being. Or. Rev. Stat. §§ 127.800 *et seq.* (2003). The Oregon law expressly provides that a physician cannot "be subject to civil or criminal liability or professional disciplinary action" for engaging in the conduct authorized by the Oregon law. *Id.* § 127.885 (1).

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[4] This is why the dispensing of controlled substances is regulated under the CSA by "provid[ing] for control . . . through registration of manufacturers, wholesalers, retailers, and all others [including physicians] in the legitimate distribution chain...." H.R. Rep. No. 91-1444, *supra*, Pt. 1, at 3, 6 (1970), *reprinted in* 1970 U.S.C.C.A.N. 4566, 4569.

The drugs dispensed in the lethal conduct authorized by the Oregon law are controlled substances regulated under the Federal CSA. Pet. App. 114a (Memorandum for the Attorney General, June 27, 2001). Generally, such substances are among those listed in Schedule II of the CSA. *Id.; see also* Pet. App. 65a (opinion of the district court).

The conduct now authorized as legitimate and immune from prosecution under Oregon law is a prosecutable crime carrying serious penalties under the provisions of the Federal CSA.

Under the CSA, it is a federal crime for a physician to "dispense" a controlled substance without a legitimate medical purpose in the usual course of medical treatment.[5] *See* 21 U.S.C. §§ 841(a)(1), 802(21); 829; 21 C.F.R. § 306.04(a) (1973) (re-designated as 21 C.F.R. § 1306.04(a) (1975); *see also United States v. Moore,* 423 U.S. 122, 124, 139 (1975) (holding that a physician can be convicted under the CSA when acting outside professional limits).

When "death . . . results from the use of such substance" dispensed, the dispensing physician faces

[5] Whether the physician acted outside authorized professional limits is not an element of the offense that the government needs to negate; rather, it is an affirmative defense available to the practitioner who carries the burden of going forward with the evidence concerning the exception. 21 U.S.C. § 885(a)(1); *Steele*, 147 F.3d at 1318-20 (11th Cir. 1998) (en banc) (and cases cited therein). Congress clearly did not intend an exception for non-medical use of controlled substances for purposes harmful to life. There is no expression within the CSA of any such exception. Permitting states to alter the CSA by injecting such an exception holds the potential to gut the full intent of the federal law. Under the appellate court's decision, for example, California could pass a law permitting physicians to prescribe and dispense controlled substances to assist patients to get "high" in order to deal with stress.



significant penalties under the CSA. *See* 21 U.S.C. § 841 (b)(1)(C) (prescribing up to life in prison for dispensing Schedule II controlled substances in violation of § 841(a) where death results from the use of the drug); *see also Moore*, 423 U.S. at 132 (1975) (recognizing that Congress geared the CSA's penalties "to the nature of the violation, including the character of the drug involved.").

It is worth noting that Congress also expressed disapproval of physician-assisted suicide in its Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, (1997), 111 Stat. 23 (codified at 42 U.S.C. § 14401 et seq.). There, Congress expressly stated the principal purpose of the Act was "to continue current Federal policy by providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual." 42 U.S.C. § 14401(b). The Assisted Suicide Funding Restriction Act thus provides further confirmation that Congress, in the CSA, intended to proscribe the dispensing of controlled substances by physicians to assist in the killing of human life.

Article VI of the United States Constitution states:

> This Constitution, and *the Laws of the United States* which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the . . . laws of any State to the Contrary notwithstanding. U.S. Const. art. VI (emphasis added).

The Federal CSA expressly preempts state laws to the extent "there is a positive conflict between [a provision

of the CSA] and that state law so that the two cannot consistently stand together." 21 U.S.C. § 903. To be sure, nothing in the CSA prevents a state from enacting its own stricter drug legislation, or prosecuting drug offenses at the state level. *Id.* And, nothing in the Federal CSA preempts a state from regulating within the field of physician-assisted suicide (i.e., nothing in the CSA preempts a state law authorizing physician assisted suicide *per se*).

Under conventional conflict preemption principles, however, the Federal CSA clearly preempts Oregon's statute authorizing *the dispensing of controlled substances* to assist suicide. The CSA proscribes the dispensing of controlled substances by physicians without a legitimate medical purpose in the usual course of medical treatment—and provides severe penalties when "death . . . results from the use of such substance . . . ." *See* §§ 841(a)(1), 802(21), 829; 21 C.F.R. § 1306.04(a) (1975); *Moore*, 423 U.S. at 124 (1975); and 21 U.S.C. § 841 (b)(1)(C). Oregon's law, on the other hand, expressly authorizes—and immunizes against prosecution—the lethal dispensing proscribed and severely penalized by the CSA. Thus, the two statutes here conflict to such an extent that they cannot consistently stand together.

Moreover, even if the CSA did not expressly preempt the Oregon statute, implied preemption exists where "compliance with both federal and state regulations is a physical impossibility." *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (internal quotation marks omitted) (citing *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992)). The mutually exclusive provisions of the CSA and Oregon law governing the dispensing of controlled substances make it impossible for a dispensing physician to comply with both. In such situations, this Court has deemed the state law preempted—even where a distinctive state interest is at stake. *See, e.g., Hisquierdo v. Hisquierdo*, 439 U.S. 572,



581 (1979) (finding state community property law preempted by federal military pay law).

Thus, the Ninth Circuit's analysis, granting Oregon's request to enjoin the United States from enforcing the Federal CSA, is incompatible with the Supremacy Clause in Article VI of the United States Constitution. The CSA and its implementing regulations plainly proscribe, and therefore preempt, Oregon's law authorizing the dispensing of drugs to assist in the death of a human being—even *without considering* the Attorney General's statutorily authorized reasonable interpretation of the CSA's implementing regulation at issue here. As discussed in more detail in section D of this brief, this interpretive rule confirmed that dispensing controlled substances to assist suicide violates the CSA, and verified that assisting suicide is not a "legitimate medical purpose" within the meaning of 21 C.F.R. 1306.04. Pet. App. 100a (AG Order no. 2534-2001). When this reasonable interpretation of the CSA's implementing regulation is added into the analysis, the certainty of federal preemption is irrefutable.

At bottom, the Ninth Circuit's analysis incorrectly presumes this case is about Oregon's right to regulate the practice of medicine—suggesting that the Attorney General's ruling alters the usual constitutional balance between the states and federal government. Pet. App. at 11a (court of appeals opinion). The problem with the appellate court's federalism analysis is that it analyzes oranges when this case is about apples. This case is not about the regulation of medical practice; it is about the right of the federal government to regulate controlled substances in a uniform manner.[6]

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[6] We also note that the appellate court over-states Oregon's situation, given that Oregon stands alone among the fifty states in having radically departed from accepted medical practice. Physician-assisted suicide bills

### C. Dispensing Controlled Substances to Assist Suicide Is Not a Traditional State Medical Practice Protected from Federal Regulation

The CSA, as interpreted by the Attorney General, does not interfere with Oregon's regulation of a traditional state function. Nothing in the record suggests that dispensing drugs to assist suicide is a traditional or legitimate medical practice subject to state regulation. As such, Oregon has no peculiar local, historical, or traditional interest in its regulation. It certainly, therefore, has no right to prevent federal enforcement of the federal drug laws under the CSA.

The Hippocratic Oath, written during the fifth to fourth centuries B.C., declares, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." In keeping with that fundamental principle of medicine, the AMA and more than 40 other national and state medical and health care organizations have urged on this Court that "the ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. . . ." Brief of the American Medical Ass'n, American Nurses Ass'n, American Psychiatric Ass'n, et al., as Amicus Curiae in Support of Petitioners at 5, *Glucksberg* (No. 96-110), *available at* 1996 WL 656263.

The AMA has "reexamined and reaffirmed" that "physician-assisted suicide remains 'fundamentally incompatible with the physician's role as healer, would be

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in more than 20 states have failed in the past decade, whereas 16 bills prohibiting it have been enacted in the past decade and a half. Yale Kamisar, *The Rise and Fall of the "Right" to Assisted Suicide*, in Foley & Hendin, eds., *The Case Against Assisted Suicide, For the Right to End-of-Life Care* 91 (2002) (citations omitted).



difficult or impossible to control, and would pose serious societal risks.'" *Id.* Thus, in reality, the Oregon law authorizes and protects a non-traditional, deadly practice using federally controlled substances. Such a practice cannot be considered medicine (traditionally regulated as a state function) as Oregon professes it to be. Thus, if suicide is not medicine, Oregon cannot, in its authorization of the use of federally controlled substances to assist suicide, claim to be regulating medicine as a traditional state function. Assisted-suicide law cannot be regulating medicine as a traditional state function.

Moreover, relatively few instances even exist in which Oregon has invoked its state law. These few instances hardly suggest a significant local impact. Certainly no widespread impact on the practice of medicine in Oregon exists from the Attorney General's interpretation of the CSA. Up until the time when Oregon passed its law, the practice of medicine in Oregon (and in every other state) did not involve assisting suicide using federally controlled substances. Oregon's federalism argument is, therefore, a canard where the federal regulation has no direct effect on truly traditional state medical practice.

To be sure, Oregon can regulate whether its physicians must be licensed. Oregon can also provide that physicians must keep their patients' records confidential—though even that duty is the subject of federal standards. *See* Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996). Oregon's attempt to legitimize the misuse of federally controlled substances to take human life (and to provide immunity to physicians violating federal regulations prohibiting that misuse), however, cannot stand.

## D. THE ATTORNEY GENERAL ACTED WITHIN HIS STATUTORY AUTHORITY

The court of appeals erred when it held that the interpretive rule promulgated by the Attorney General fell outside his statutory authority. Pet. App. 9a (court of appeals opinion).

As previously discussed, the Attorney General's interpretive rule confirmed that dispensing controlled substances to assist suicide violates the CSA. It also verified that helping one to kill oneself is not a "legitimate medical purpose" within the meaning of 21 C.F.R. 1306.04. Pet. App. 100a (AG Order no. 2534-2001, 66 Fed. Reg at 56,608). The interpretive rule further concluded that "[s]uch conduct by a physician registered to dispense controlled substances *may* 'render his registration . . . inconsistent with the public interest' and therefore subject to *possible* suspension or revocation." *Id.* (quoting 21 U.S.C. § 824(a)(4)) (emphasis added). For the reasons discussed below, the Attorney General acted within his statutory authority when he promulgated this interpretive rule.

Congress, through the CSA, used the concept of "registration" to identify those physicians who operate "beyond the bounds of professional practice." *Moore*, 423 U.S. at 139 (1975). Physicians and others, who dispense a controlled substance, must "obtain from the Attorney General a registration issued in accordance with the rules and regulations promulgated by him." 21 U.S.C. § 822 (a)(2). Under the CSA, physicians and others registered by the Attorney General to dispense controlled substances are authorized to dispense such substances only "to the extent authorized by their registration and in conformity with the [provisions of the CSA]." 21 U.S.C. § 822 (b). Thus, only



"the lawful acts of registrants are exempted" from prosecution. *Moore*, 423 U.S. at 130 (1975).

Congress expressly granted the Attorney General the authority "to promulgate rules and regulations . . . relating to the registration and control of the . . . dispensing of controlled substances and to the registration and control of regulated persons and regulated transactions." 21 U.S.C. § 821.[7]

Under 21 U.S.C. § 823(f), Congress gave the Attorney General the express authority to deny an application for registration "if he determines the issuance of such registration is inconsistent with the public interest." Moreover, Congress also expressly gave the Attorney General the authority to suspend or revoke a registration authorized pursuant to section 823 if the Attorney General finds that the registrant committed an act that would "render his registration under section 823 [of the CSA] inconsistent with the public interest as determined under such section." 21 U.S.C. § 824.

In denying, revoking, or suspending an application, the Attorney General must consider the following factors in determining the public interest:

> (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

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[7] Congress expressly further granted the Attorney General the authority to "promulgate and enforce any rules, regulations, and procedures" deemed "necessary and appropriate for the efficient execution of his functions under this subchapter." 21 U.S.C. § 871(b).

(2) The applicant's experience dispensing . . . controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

21 U.S.C. § 823.

Most of the drugs dispensed in the lethal conduct authorized by the Oregon law likely fall within Schedule II of the CSA, the "most strictly regulated category of substances available for non-research purposes." Pet. App. 114a (Memorandum for the Attorney General, June 27, 2001). *See also* Pet. App. 65a (opinion of the district court).

In 21 U.S.C. § 829, Congress mandated the following in connection with the dispensing of Schedule II controlled substances:

> Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule II . . . may be dispensed without the written prescription of a practitioner, [with emergency exceptions not relevant to the discussion at bar]."[8]

[8] The word "dispense" means "to deliver a controlled substance to an ultimate user . . . by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance . . . ." 21 U.S.C. § 802(10). "'Ultimate user' means a person who has lawfully obtained ... a controlled substance for his own use . . . ." 21 U.S.C. § 802 (27). The term "practitioner" includes a "physician . . . licensed, *registered*, or otherwise permitted, by the United States or the jurisdiction in which he practices . . . [to] dispense . . . a controlled substance in the course of professional practice . . . ." 21 U.S.C. § 802 (21) (emphasis added).



Pursuant to the above discussed rulemaking authority vested in the Attorney General by Congress, the Attorney General, in the early 1970's, enacted regulations pursuant to Section 829:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning of this Act and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provide for violations of the provisions of law relating to controlled substances.

21 CFR § 306.04(a) (1973) (redesignated as 21 C.F.R. § 1306.04(a) (1975).[9]

If the Attorney General in the early 1970's promulgated the above rule pursuant to statutory authority,

[9] *See also*, 21 U.S.C. § 830 (b)(3)(ii) *Regulation of Llisted Chemicals –l Mail Order Reporting* – "The term 'valid prescription' means a prescription which is issued for a legitimate medical purpose by an individual practitioner licensed by law to . . . prescribe the drugs concerned and acting in the usual course of the practitioner's professional practice."

then the Attorney General in 2001 certainly had the authority to interpret what it means. Indeed, as noted above, Congress, in 21 U.S.C. § 821, expressly granted the Attorney General authority "to promulgate rules and regulations . . . relating to the registrations and control of the . . . dispensing of controlled substances and to the registration and control of regulated persons and regulated transactions." The Attorney General's interpretive ruling directly promotes the CSA's purposes, by restricting use of controlled substances to legitimate medical purposes. It promotes the medical use of drugs, furthering the public interest in a manner perfectly consistent with the broad intent of Congress. Thus, when the Attorney General published the interpretive rule, confirming that dispensing controlled substances to assist suicide violates the CSA, and verified that assisting suicide is not a "legitimate medical purpose" within the meaning of 21 C.F.R. 1306.04, he acted well within his congressionally authorized authority. Pet. App. 100a (AG Order no. 2534-2001, 66 Fed. Reg. at 56,608).

Moreover, it was reasonable for the Attorney General to subsequently conclude in the interpretive rule that "[s]uch conduct by a physician registered to dispense controlled substances *may* 'render his registration . . . inconsistent with the public interest' and therefore subject to *possible* suspension or revocation." Pet. App. 100a (AG Order no. 2534-2001, 66 Fed. Reg. at 56,608 (quoting 21 U.S.C. § 824(a)(4))) (emphasis added).

The court of appeal's holding that the Attorney General's action exceeded statutory authority because it "evaluates public interest under 21 U.S.C. § 823 without considering all five factors required by that subsection" is misplaced. Pet. App. 17a (court of appeals opinion).



This part of the Attorney General's interpretive rule is merely public notice of a logical consequence that *may* come to one from ignoring the previously established premise that dispensing drugs to assist one to kill oneself is not a legitimate medical practice and violates the CSA. In this regard, although the Attorney General certainly evaluated the public's interest in promulgating the interpretive rule, nothing in the law requires him to consider all five factors delineated in 21 U.S.C. § 823(f). Under the CSA, the Attorney General is required to consider these five factors only when denying, revoking, or suspending an application for a registration. 21 U.S.C. §§ 823(f), 824. Nothing in the record indicates that the Attorney General has even contemplated taking such action against the named plaintiffs. Thus, the court of appeals erred since no statutory authority required the Attorney General to consider the five factors when promulgating the interpretive rule.

### E. Enjoining the United States from Protecting the Citizenry against Dispensing Drugs to Kill a Person, Creates a Culture of Death with Serious Implications

The court of appeals mandated that the United States must not enforce the nation's drug laws against physicians who dispense controlled substances to assist in the killing of a human being. *Amici* believe that human beings are made in the image of God and that, therefore, every life is sacred. *Genesis* 1:26. Underlying the court of appeals decision is a rejection of this inviolable standard present in the natural law, divine law, and positive law, in favor of a morally-relative standard where each individual chooses when and whether a human life has value.

Ultimately, allowing the dispensing of federally controlled drugs to assist suicide flows directly from the

fundamentally erroneous premise that human life in certain conditions has no positive value. That premise has incalculably serious implications for all of us. Here, an appellate court has ruled that individuals have the right to take life in certain situations, and that the United States cannot enforce the federal drug laws in ways that protect life. When we abandon moral absolutes today, it becomes easy tomorrow to choose death in other ways, for other people, in other situations, since the positive value of life has become an immorally-relative individual choice.

The prominent ethicist Sissela Bok concluded, "No society has yet worked out the hardest questions of how to help those patients who desire to die, without endangering others who do not." Sissella Bok, *Physician-Assisted Suicide*, in *Euthanasia and Physician-Assisted Suicide* 139 (Gerald Dworkin, et al., eds., (1998)).

Prior to the enactment of the Federal CSA,[10] euthanasia societies grew during the late 19th and early 20th century eugenics movements in the United States and Europe. Kathleen Foley and Herbert Hendin, *Introduction*, in *The Case Against Assisted Suicide, For the Right to End-of-Life Care* 6-7 (Foley & Hendin eds., 2002). Thirty states passed sterilization laws embraced by both Presidents Theodore Roosevelt and Woodrow Wilson. *Id.*

The Nazis legalized voluntary euthanasia, and then involuntarily euthanized hundreds of thousands of the mentally ill; they then extended euthanasia's reach to Jews, gypsies, and other "undesirables." *Id.* at 7.

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[10] The Ninth Circuit erred in relying on former Attorney General Reno's January 5, 1998 letter suggesting that the CSA did not prohibit prescription-assisted suicide. *See* Pet. App. 7a. The Reno letter assumed, ahistorically, that the CSA was written before there was any consideration of assisted suicide.



As late as the 1940s, this country's leading euthanasia proponent, Dr. Foster Kennedy, continued to advocate compulsory euthanasia for retarded children on eugenics grounds. By the 1970s, the euthanasia movement's focus shifted to easing the "burden" of caring for the elderly, and then to easing suffering, *id.* at 8,—though notably, no suffering requirement exists in the Oregon law, which purports instead to be based on personal choice. The Oregon law requires the physician to advise the patient of palliative care and hospice, but does not require that the physician have any training in either and requires no palliative care consultation.

While utterly failing to protect the family of the patient, the Oregon law grants "good faith" immunity to the physician and fails to provide an enforcement mechanism for physician non-compliance. Moreover, inadequate data collection requirements limit any possible study of the Oregon experiment. For example, the form used by Oregon to effectuate the killing requires no disclosure of the reason for the patient's request. *Id.*

The Dutch experiment in physician-assisted suicide failed frighteningly. Dutch legal requirements were consistently violated and could not be enforced. *Id.* at 10. Sixty percent of Dutch assisted suicide cases go unreported. *Id.* Most non-reporting involves cases in which physicians failed to follow established guidelines for voluntariness or consultation.

Worse, in several thousand cases each year physicians ended their patient's life without the patient's consent. *Id.* Twenty-five percent of physicians terminated one or more patient's life without request. *Id.* In the 1995 study year, 40 percent of the more than 6,000 cases in which

physicians actively intervened to cause death involved no explicit request from the patient. Herbert Hendin, *The Dutch Experience*, in Foley & Hendin, *supra*, at 105; *see also* Zbigniew Zylicz, M.D., *Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician*, in Foley & Hendin, *supra*, at 123.

Each major Dutch measure enacted to control and regulate physician-assisted suicide (including informed consent, consultation, and reporting) largely failed, was modified, or was violated. Foley & Hendin, *supra*, at 103 (citing C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991)). This Court in *Washington v. Glucksberg*, 521 U.S. 702, 733 (1997), recognized that "what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to solve and contain." Indeed, what we sow today, we will reap tomorrow.

As the fundamental units of society, families must be protected and promoted by the law and by legal institutions, if order and liberty are to flourish. Yet clinical research shows that suicides in general and physician-assisted suicides more particularly, devastate families. M.D. Reed and J.Y. Greenwald, *Survivor Victim Status, Attachment and Sudden Death Bereavement*, 21 J. of Suicide and Life-Threatening Behavior 385-401 (1991); N.L. Farberow, D.E. Gallagher-Thompson, N.J. Gilewski, and L.W. Thompson, *Changes in Grief and Mental Health of Bereaved Spouses of Older Suicides*, 47 J. Gerontology 357-66 (1992), both cited in Kathleen Foley and Herbert Hendin, *The Oregon Experiment*, in *The Case Against Assisted Suicide, For the Right to End-of-Life Care* 158 (Foley & Hendin, ed. 2002) (noting the "devastating grief and guilt that we see in survivors of suicide").



Imagine the shock of an adult child making the weekly visit to a parent's nursing home, only to discover that a physician proscribed and dispensed a federally controlled substance to help the parent commit suicide the day before. (Oregon's law requires no pre-suicide notification to families.)

The toll on family life is incalculable. Allowing physicians to dispense drugs to assist in killing has an insidious effect on families who support seniors, burdening both the family and the dying. The number of patients in Oregon reporting a concern about being a burden on the family increased from 12 percent in 1998 to 63 percent in 2000, subsequent to the passage of Oregon's physician-assisted suicide law. *Id.* at 162. Physician-assisted suicide creates in practice a frightening "duty to die"—frightening because the practice of physician-assisted suicide has been shown to be so imperfect a means of death that in one Dutch study fully 20 percent of patients given what was considered to be a lethal dose lived for more than three hours, in some cases requiring the physician to intervene with a lethal injection which would be illegal under the Oregon law. *Id.* at 166 (citing J.H. Groenewould, A. van der Heide, B.D. Onwuteaka-Philipsen, D.L. Willems, P.J. van der Maas, and G. van der Wal, *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 New England J. Med. 551-56 (2000). Families are occasionally called on to intervene with pillows or plastic bags. Foley & Hendin, *supra* at 164 (citations omitted).

The court of appeals decision rejects the inviolable standard serving as the foundation for the Hippocratic Oath, as well as the AMA's view that physician-assisted suicide is fundamentally incompatible with the physician's role as healer. Underlying its decision instead is a morally-relative

foundation, where each individual chooses when and whether a human life has positive value. The serious implications for our nation that accompany such a choice are clear. Proper historical foundations do matter. Because they do, *amici* urge this Court to reverse the decision of the court of appeals.

## CONCLUSION

This case implicates important federalism concerns vital to proper constitutional governance under the rule of law. Mutually exclusive provisions of the Federal CSA and Oregon law make it impossible for a dispensing physician to comply with both laws. Thus, the Federal CSA preempts the Oregon law. The appellate court's analysis, granting Oregon's request to enjoin the United States from enforcing the Federal CSA, is incompatible with the Supremacy Clause in Article VI of the United States Constitution.

The Attorney General's interpretive rule confirmed that dispensing controlled substances to assist suicide violates the CSA, and verified that assisting suicide is not a "legitimate medical purpose." The Attorney General, in promulgating this rule, acted well within a plethora of statutory authority expressly allowing him to do so.

*Amici* ask that this Court restore the right of the federal government to enforce our nation's drug laws under the CSA. Undeniably, we stand at a statutory construction site. If, in the name of an individual's morally relative choice, we enjoin the federal government from proscribing the dispensing of drugs to kill a human being, we merely create an illusion of a nation willing to protect fundamental freedoms. Such a course inevitably erodes the fundamental foundations of our country. As structural institutions of free



government stand for a time, the essence for which they stand ceases to exist. Who we are morally, as a nation, matters. Those who came before us built a constitutional, democratic republic upon fundamental foundations of decency. It is now our watch. It is well for us to recall, therefore, the ancient truth that "righteousness exalts a nation." *Proverbs* 14:34.

For the reasons discussed, *amici* urge this Court to reverse the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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